Empl ID:
Agency:
Location:

Health Care and Benefits Division
PO Box 200127
Helena MT 59620-0127

INDIVIDUAL BENEFITS STATEMENT FORM

INSTRUCTIONS & DEADLINE FOR ELECTIONS - Review your elections carefully by verifying the types and amounts of coverage, reviewing benefit offerings in your Annual Change booklet, and making any necessary changes to the appropriate sections of this form or on-line by the October 24, 2008 deadline. All forms must be postmarked on or before **October 24, 2008** and returned to the Health Care and Benefits Division. Forms may be sent through the U.S. Post Office mail service, through the State of Montana (Deadhead) mail service, or dropped off at 125 N. Roberts, room 125. Giving your form to your employer or payroll personnel does not constitute filing with the Health Care and Benefits Division. **If you have NO changes, and DO NOT wish to enroll in Flexible Spending, Vision, or Long Term Disability, you do not need to return this form. If you completed your enrollment on-line, do not submit this form.**

BENEFIT OPTIONS	*2008 COVERAGE	2008 PREMIUMS	2009 PREMIUMS
Medical			
Dental			
Vision			
Basic Life			
Dependent Life			
Employee Supplemental			
Spouse Supplemental			
AD&D			
Long-Term Care			
Pre-Tax Plan			
Long Term Disability			
State Contribution			
TOTAL OUT-OF-POCKET PREMIUM COSTS			

*As of September 18, 2008

Member & Dependent Information: Please verify that the information for the following currently covered dependents is accurate making changes where necessary. If a dependent's tax status has changed, complete a Declaration of Tax Status form available on-line at www.benefits.mt.gov.

Delete	Add	Coverage**	Name	Birthdate	Relationship*	Social Security #	Tax Status
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						
❑	❑						

*Rel. = Relationship • E = Employee • SP = Spouse • D = Daughter • S = Son • X = Disabled
**Coverage = M=Medical • D=Dental • V=Vision

I. MEDICAL - Required for all employees. Dependents cannot be added to medical coverage unless there has been a qualifying event (see page 18 in the booklet). Delete a dependent from coverage by checking the **Delete** box preceding each dependent's name and circle the type of coverage to be deleted.

❑ No changes

❑ Change Medical Plan to: ❑ Traditional ❑ Blue Choice ❑ New West ❑ Peak Health

All Joint Core election changes must be made on this form, not on-line.

❑ Elect Joint Core* (only for married spouses who are both employed by the State and have covered dependents)
*Employee's Joint Core Partner & SSN _____

❑ Cancel Joint Core (Spouse must also submit their Individual Benefit Statement to cancel.)

II. DENTAL - Required for all employees

❑ No changes
❑ Changes

❑ Add a dependent(s): check the **Add** box on this page, write coverage type "D" and the other requested information.
❑ Delete a dependent(s): check the **Delete** box in the dependent section next to the appropriate dependent(s) and circle the coverage to be deleted.

III. LONG TERM DISABILITY INSURANCE - Guaranteed issue for 2009!

❑ No changes ❑ Yes, I want to enroll ❑ No, I do NOT want to enroll

Name:
Emp ID:
Home Phone:
Work Phone:

IV. VISION COVERAGE - Enrollment is not automatic! Please choose the appropriate box below. If you wish to cover dependents that are not already listed in the dependent section on the front of this form, please check the **Add** box and write coverage type "V" and the other requested information.

- ❑ Employee only coverage
- ❑ Employee and spouse
- ❑ Employee and children
- ❑ Employee and family
- ❑ No, I do NOT want to enroll

V. LIFE INSURANCE - Basis for calculating minimum and maximum coverage $

Check out the limited opportunity to get up to $10,000 in spouse life without evidence of insurability in your Annual Change booklet (see page 26 in the booklet).

- ❑ No changes
- ❑ Changes
  - ❑ **Employee Supplemental Life - $5,000 increments up to $500,000** (*Applications will be sent if desired amount is higher than current coverage).* ❑ Cancel ❑ Add or Change - New total amount:_____
  - ❑ **AD & D with dependents - $25,000 increments up to $500,000** ❑ Cancel ❑ Add or Change - New total amount:_____
  - ❑ **AD & D without dependents - $25,000 increments up to $500,000** ❑ Cancel ❑ Add or Change - New total amount:_____
  - ❑ **Dependent Life** ❑ Cancel
  - ❑ **Spouse Supplemental Life- $5,000 increments up to 100% of Plan C** (*Applications will be sent if new election exceeds $10,000)* ❑ Cancel ❑ Add or Change - New total amount:_____

VI. LONG-TERM CARE INSURANCE

❑ No changes ❑ Please send me an enrollment kit ❑ Cancel

VII. FLEXIBLE SPENDING ACCOUNTS - Enrollment is NOT automatic! You must select an account and indicate an amount to enroll in an FSA during 2009. If you elect an FSA, you must also participate in the Pre-Tax Plan.

Please calculate BOTH your Monthly & Yearly FSA amounts keeping in mind the monthly amount must be divisible evenly by two. Your election will be adjusted to an even amount if necessary. Include any unused State Benefits Contribution in this amount.

❑ Medical Expense FSA _____**MONTHLY AMT** ($10 min/$416.66 monthly max)
_____**YEARLY AMT** ($120 min/$4999.92 yearly max)

❑ Dependent Care FSA_____**MONTHLY AMT** ($10 min./$416.66 monthly max.)
_____**YEARLY AMT** ($120 min/$4999.92 household yearly max)

VIII. PRE-TAX PLAN - Required for FSA participants and to have qualifying out-of-pocket expenses withheld on a pre-tax basis. Your current election will automatically continue, unless you indicate otherwise below. **All Pre-tax election changes must be made on this form, not on-line.**

- ❑ No changes
- ❑ Yes, I want my deductions withheld on a pre-tax basis ❑ No, I want my deductions withheld on an after-tax basis

VIIII. READ AND SIGN

I request the election changes indicated above and authorize the associated payroll deduction. I understand that a Confirmation Statement to confirm my 2009 benefits will be mailed the week of November 17, 2008. I understand that if I am adding a new dependent to my dental or vision benefits, I will receive a Declaration of Tax Status form to complete and failure to this form will result in my dependents being defaulted to a non-qualified status. I understand that other application forms may be required for the changes that I have requested and I am responsible for completing and returning the application materials before processing of my requested changes will continue.

I have read the informational material describing Flexible Spending Accounts and understand the participation conditions and requirements. I request participation in the FSA(s) listed above for the 2009 Benefit Year, and authorize the State of Montana to reduce gross salary by the amounts indicated. I understand my election amount will remain in effect for the entire Benefit Year, and only eligible expenses incurred during the Benefit Year (2009) may be claimed for reimbursement. I realize this agreement will **NOT** continue for subsequent Benefit Years. This agreement revokes all prior Employee Enrollment/Change and Salary Reduction Agreements signed by me for this benefit year.

Signature: _____ Date:_____

ADMINISTRATIVE USE ONLY

Date Benefit Statement received/postmarked: _____
Date additional forms sent: _____
By whom: _____
Forms sent:
- ❑ Life Insurance Application
- ❑ Life Insurance Enollment/Change Form
- ❑ Long-term Care Enrollment Kit

FSA Type	Monthly Deduction	# of Deductions	Annual Election
Medical	_____	12	_____
Dependent Care	_____	12	_____